		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040931

Facility Name: COUNTRYSIDE CARE CENTRE

Address: 2330 W. GALENA (Number) AURORA (City) 60506 (Zip Code)

County: COUNTY

Telephone Number: (630) 896-4686 **Fax #** (630) 896-7868

IDPA ID Number: 36-3961908

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	207	TOTALS	207	75,555	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,594	1,004	8,551	14,149	8
9	SNF/PED					9
10	ICF	45,199	11,251	2,852	59,302	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,793	12,255	11,403	73,451	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.22%

D. How many bed-hold days during this year were paid by Public Aid?
159 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
OUTPATIENT THERAPY

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 3,884

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	296,323	27,185	12,231	335,739		335,739		335,739			1
2	Food Purchase		250,677		250,677		250,677	(2,854)	247,823			2
3	Housekeeping	236,038	47,154		283,192		283,192		283,192			3
4	Laundry	54,237	21,385	3,901	79,523		79,523		79,523			4
5	Heat and Other Utilities			176,241	176,241		176,241		176,241			5
6	Maintenance	38,906	49,365	57,356	145,627		145,627	1,581	147,208			6
7	Other (specify):*			38,595	38,595		38,595		38,595			7
8	**TOTAL General Services**	625,504	395,766	288,324	1,309,594		1,309,594	(1,273)	1,308,321			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	3,400,967	124,241	43,293	3,568,501		3,568,501	14,130	3,582,631			10
10a	Therapy	74,444			74,444		74,444		74,444			10a
11	Activities	108,220	4,940	13,764	126,924		126,924		126,924			11
12	Social Services	50,560		1,646	52,206		52,206		52,206			12
13	Nurse Aide Training			2,092	2,092		2,092		2,092			13
14	Program Transportation			110	110		110		110			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,634,191	129,181	66,905	3,830,277		3,830,277	14,130	3,844,407			16
	C. General Administration											
17	Administrative	187,900		800,192	988,092		988,092	(776,889)	211,203			17
18	Directors Fees											18
19	Professional Services			242,685	242,685		242,685	13,972	256,657			19
20	Dues, Fees, Subscriptions & Promotions			86,155	86,155		86,155	(54,979)	31,176			20
21	Clerical & General Office Expenses	159,357	49,818	55,024	264,199		264,199	132,996	397,195			21
22	Employee Benefits & Payroll Taxes			803,000	803,000		803,000		803,000			22
23	Inservice Training & Education			14,386	14,386		14,386		14,386			23
24	Travel and Seminar							14,394	14,394			24
25	Other Admin. Staff Transportation			4,584	4,584		4,584		4,584			25
26	Insurance-Prop.Liab.Malpractice			223,223	223,223		223,223	30,234	253,457			26
27	Other (specify):*			327,174	327,174		327,174	(327,174)				27
28	**TOTAL General Administration**	347,257	49,818	2,556,423	2,953,498		2,953,498	(967,446)	1,986,052			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,606,952	574,765	2,911,652	8,093,369		8,093,369	(954,589)	7,138,780			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: COUNTRYSIDE CARE CENTRE **#0040931** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,200	
	REPAIRS & MAINTENANCE		1,031	
			0	12,231
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,901	
			0	3,901
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		45,034	
	ELECTRICITY		75,023	
	WATER		56,184	
	CABLE TV - LOBBY		0	
			0	176,241
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		10,297	
	PAINTING & DECORATING		1,353	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		32,990	
	ELEVATOR MAINTENANCE & REPAIR		4,648	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,220	
	FIRE SERVICE		2,848	
			0	
			0	
			0	57,356
7	**OTHER**			
	SCAVENGER		36,947	
	SECURITY SERVICE		1,648	38,595
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	5,272	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,112	
	PHARMACY CONSULTANT	XVIII B 39-2	2,400	
	UTILIZATION REVIEW FEES	XVIII B 47-2	6,000	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	27,509	
			0	
			0	43,293
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		11,370	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,394	
			0	13,764
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,646	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	1,646
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	2,092	2,092

Facility Name & ID Number COUNTRYSIDE CARE CENTRE #0040931 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		110	110
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	800,192	800,192
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	32,624	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	210,061	
			0	242,685
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	31,133	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,859	
	EMPLOYEE WANT ADS	XIX F	10,430	
	CONTRIBUTIONS	VI 20 XIX F	285	
	DUES & SUBSCRIPTIONS	XIX F	10,596	
	LICENSES & PERMITS	XIX F	7,103	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	13,447	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,064	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,238	86,155
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		7,409	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	8,636	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		1,228	
	TELEPHONE		36,797	
	MESSENGER SERVICE		954	
			0	55,024

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	347,615	
	UNEMPLOYMENT COMPENSATION	XIX D	42,297	
	WORKERS COMPENSATION INSURANCI	XIX D	127,212	
	HOSPITALIZATION INSURANCE	XIX D	265,971	
	EMPLOYEE BENEFITS - OTHER	XIX D	11,725	
	EMPLOYEE PHYSICAL EXAMS	XIX D	314	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	7,866	
	CHICAGO HEAD TAX	XIX D	0	803,000
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		14,386	14,386
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,584	4,584
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		223,223	223,223
27	**OTHER**			
	BAD DEBTS	VI 24	327,174	
			0	327,174

GRAND TOTAL COLUMN 3 OTHER 2,911,652

COUNTRYSIDE CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2003

TOTAL FOOD PURCHASE	250,677	PATIENT MEALS	220353
LESS SALES TAX	(2,854)	ADD EMPLOYEE MEALS	0
NET FOOD	247,823	TOTAL MEALS/YEAR	220353
TOTAL PATIENT CENSUS	73,451	NET FOOD	247823
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	220353
TOTAL PATIENT MEALS	220353	COST PER MEAL	1.12
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number COUNTRYSIDE CARE CENTRE #0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			146,623	146,623		146,623	57,421	204,044			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			152,885	152,885		152,885	666,426	819,311			32
33	Real Estate Taxes			113,786	113,786		113,786		113,786			33
34	Rent-Facility & Grounds			762,850	762,850		762,850	(740,008)	22,842			34
35	Rent-Equipment & Vehicles			21,354	21,354		21,354	9,630	30,984			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,197,498	1,197,498		1,197,498	(6,531)	1,190,967			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		183,897	315,200	499,097		499,097		499,097			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,333	113,333		113,333		113,333			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		183,897	428,533	612,430		612,430		612,430			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,606,952	758,662	4,537,683	9,903,297		9,903,297	(961,120)	8,942,177			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(146,623)	30		9
10	Interest and Other Investment Income	(8,475)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,854)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(8,636)	21		18
19	Entertainment	(31,133)	20		19
20	Contributions	(3,349)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,393)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(327,174)	27		24
25	Fund Raising, Advertising and Promotional	(8,859)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(13,447)	20		28
29	Other-Attach Schedule SEE PAGE 5A	1,581			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (550,362)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(410,758)	PG.6&6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (410,758)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (961,120)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

COUNTRYSIDE CARE CENTRE

ID# 0040931

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1,581	6	1
2	VACATION ACCRUAL		1	2
3	VACATION ACCRUAL		3	3
4	VACATION ACCRUAL		4	4
5	VACATION ACCRUAL		6	5
6	VACATION ACCRUAL		10	6
7	VACATION ACCRUAL		11	7
8	VACATION ACCRUAL		17	8
9	VACATION ACCRUAL		21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,581		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,854)	0	0	0	0	0	0	0	0	0	0	(2,854)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,581	0	0	0	0	0	0	0	0	0	0	1,581	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,273)	0	0	0	0	0	0	0	0	0	0	(1,273)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	14,130	0	0	0	0	0	0	0	0	0	14,130	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	14,130	0	0	0	0	0	0	0	0	0	14,130	16
	C. General Administration													
17	Administrative	0	(776,889)	0	0	0	0	0	0	0	0	0	(776,889)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,393)	8,443	6,922	0	0	0	0	0	0	0	0	13,972	19
20	Fees, Subscriptions & Promotions	(56,788)	1,809	0	0	0	0	0	0	0	0	0	(54,979)	20
21	Clerical & General Office Expenses	(8,636)	141,632	0	0	0	0	0	0	0	0	0	132,996	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	14,394	0	0	0	0	0	0	0	0	0	14,394	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	7,199	23,035	0	0	0	0	0	0	0	0	30,234	26
27	Other (specify):*	(327,174)	0	0	0	0	0	0	0	0	0	0	(327,174)	27
28	**TOTAL General Administration**	(393,991)	(603,412)	29,957	0	0	0	0	0	0	0	0	(967,446)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(395,264)	(589,282)	29,957	0	0	0	0	0	0	0	0	(954,589)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(146,623)	4,556	199,488	0	0	0	0	0	0	0	0	57,421	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,475)	0	674,901	0	0	0	0	0	0	0	0	666,426	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	22,842	(762,850)	0	0	0	0	0	0	0	0	(740,008)	34
35	Rent-Equipment & Vehicles	0	9,630	0	0	0	0	0	0	0	0	0	9,630	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(155,098)	37,028	111,539	0	0	0	0	0	0	0	0	(6,531)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(550,362)	(552,254)	141,496	0	0	0	0	0	0	0	0	(961,120)	45

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					MORTON GROVE, IL	
				COUNTRYSIDE HEALTH CARE CENTRE		
					MORTON GROVE, IL	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 14,130	$ 14,130	1
2	V	17	ADMINISTRATIVE	800,192	MR. BELLOWS OWNS 1.5% OF THIS FACILITY		23,303	(776,889)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		8,443	8,443	3
4	V	20	DUES & SUBSCRIPTIONS		" "		1,809	1,809	4
5	V	21	CLERICAL		" "		141,632	141,632	5
6	V	24	TRAVEL		" "		14,394	14,394	6
7	V	26	INSURANCE		" "		7,199	7,199	7
8	V	30	DEPRECIATION		" "		4,556	4,556	8
9	V	34	RENT		" "		22,842	22,842	9
10	V	35	RENT-EQUIPMENT & VEH.		" "		9,630	9,630	10
11	V								11
12	V								12
13	V								13
14	Total			$ 800,192			$ 247,938	$ * (552,254)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 762,850	COUNTRYSIDE HEALTHCARE CENTRE		$	$ (762,850)	15
16	V	19	ACCOUNTING FEES		" '		5,750	5,750	16
17	V	26	MORTGAGE INSURANCE		" '		23,035	23,035	17
18	V	30	DEPRECIATION - BLDG/IMP		" '		195,362	195,362	18
19	V	30	DEPRECIATION - EQPT/FURN		" '		4,126	4,126	19
20	V	32	AMORTIZATION - MTG COST		" '		88,217	88,217	20
21	V	32	INTEREST - MORTGAGE		" '		559,579	559,579	21
22	V	32	INTEREST - OTHER		" '		27,105	27,105	22
23	V	19	DATA PROCESSING				1,172	1,172	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 762,850			$ 904,346	$ * 141,496	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES, INC.								$		1
2	SHAEL BELLOWS	MANGMT. CNSLT	ADMIN.	1.5%	SEE ATTACHED	3.53	14.88	SALARY	23,303	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 23,303		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	493,454	9	$ 94,929	$ 94,929	73,451	$ 14,130	1
2	17	ADMINISTRATIVE	PATIENT DAYS	493,454	9	159,981	159,981	73,451	23,303	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	493,454	9	56,724		73,451	8,443	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	493,454	9	12,155		73,451	1,809	4
5	21	CLERICAL	PATIENT DAYS	493,454	9	191,338		73,451	28,481	5
6	21	CLERICAL	HOURS	1	1	113,151	113,151	1	113,151	6
7	24	TRAVEL	PATIENT DAYS	493,454	9	96,702		73,451	14,394	7
8	26	INSURANCE	PATIENT DAYS	493,454	9	48,361		73,451	7,199	8
9	30	DEPRECIATION	PATIENT DAYS	493,454	9	30,611		73,451	4,556	9
10	34	RENT	PATIENT DAYS	493,454	9	153,459		73,451	22,842	10
11	35	RENT - EQUIPMENT & VEH.	PATIENT DAYS	493,454	9	64,696		73,451	9,630	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,022,107	$ 368,061		$ 247,938	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - COUNTRYSIDE HEALTHCARE CENTRE						$	$			$	1
2	MIDLAND		X	MORTGAGE	VARIES	10/97	4,826,200			0.0745	548,868	2
3	MIDLAND		X	LOAN COST	35 YR AMORT	10/97	88,155				88,155	3
4	GMAC		X	MORTGAGE	$60,450.43	12/03	4,826,200	4,826,200	12/38	0.0540	10,710	4
5	GMAC		X	LOAN COST	35 YR AMORT	12/03	52,135	52,073			62	5
	Working Capital											
6	AMERICAN NATIONAL BNK		X	WORKING CAPITAL	VARIES	12/96	265,000		DEMAND	PRIME+	10,374	6
7	LOAN PARTNERS	X		WORKING CAPITAL	VARIES	06/99	108,600	158,145	DEMAND	PRIME+	12,482	7
8	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/98	498,989	2,110,563	DEMAND	VARIES	157,134	8
9	TOTAL Facility Related				$60,450.43		$ 10,665,279	$ 7,146,981			$ 827,785	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,665,279	$ 7,146,981			$ 827,785	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 23,035 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	98,676	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	105,650	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,974	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	106,812	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	113,786	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	89,211	8
	1999	92,112	9
	2000	94,448	10
	2001	97,597	11
	2002	105,650	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COUNTRYSIDE CARE CENTRE COUNTY COUNTY

FACILITY IDPH LICENSE NUMBER 0040931

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-19-176-009	NURSING HOME	$ 105,649.52	$ 105,649.52
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 105,649.52	$ 105,649.52

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,536 B. General Construction Type: Exterior BRICK Frame STEEL CONST. Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	130,679	1981	$ 98,000	1
2	754 BASIS ADJ.		1982	16,345	2
3	TOTALS	130,679		$ 114,345	3

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	207		1981		$ 2,111,156	$	30	$ 70,059	$ 70,059	$ 1,570,150	4
5											5
6	754 BASIS AJ			1992	403,542	12,811	31.5	12,811		147,327	6
7											7
8											8
	Improvement Type**										
9	********** RELATED PARTY - COUNTRYSIDE HEALTH CARE										9
10	BUILDING IMPROVEMENTS			1982	40,076		15			40,076	10
11	VARIOUS IMPROVEMENTS			1983	26,282		15			26,282	11
12	VINYL TILING			1984	76,250		20	3,813	3,813	74,343	12
13	ROOF REPAIR			1985	6,644	349	20	332	(17)	6,142	13
14	VARIOUS IMPROVEMENTS			1986	1,609	85	15	107	22	1,870	14
15	VARIOUS IMPROVEMENTS			1987	36,433	1,157	20	1,822	665	30,063	15
16	BLACK TOPPAVING			1988	1,594	57	15	57		1,594	16
17	HOT WATER PIPING			1988	5,837	185	31.5	185		2,814	17
18	ROOFING IMPROVEMENTS			1989	51,879	1,647	31.5	1,647		24,225	18
19	SHOWER STALLS			1990	7,000	222	31.5	222		2,997	19
20	PAVING			1990	7,930	529	15	529		7,141	20
21	VARIOUS IMPROVEMENTS			1991	24,486	777	20	1,224	447	15,308	21
22	VARIOUS IMPROVEMENTS			1992	43,773	1,390	31.5	1,390		15,849	22
23	VARIOUS IMPROVEMENTS			1993	13,286	421	31.5	421		4,570	23
24	VARIOUS IMPROVEMENTS			1993	40,598	1,041	39	1,041		10,712	24
25	VARIOUS IMPROVEMENTS			1994	221,766	5,494	39	5,494		50,410	25
26	VARIOUS IMPROVEMENTS			1994	55,030	4,167	15	4,167		39,583	26
27	KITCHEN REMODEL/SIGNS			1995	32,836	842	39	842		7,510	27
28	ELECTRICAL & LIGHTING			1995	31,634	811	39	811		5,977	28
29	ROOFING/DOORS/DUCTWORK			1995	15,211	390	39	390		2,890	29
30	ROOF REPAIRS/FIRE DAMPERS			1996	4,300	110	39	110		867	30
31	BLACK TOPPAVING			1996	3,400	87	39	87		620	31
32	DUCTWORK			1996	8,584	220	39	220		1,549	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REMOVE & REPLACE HVAC ROOF UNITS	1998	$ 28,363	$ 727	39	$ 727	$	$ 3,847	37
38	ROOF REPAIRS - PATCHING	1998	6,500	167	39	167		981	38
39	STAINLESS DUCTWORK - KITCHEN EXHAUST	1998	3,987	102	39	102		608	39
40	BOILER	1998	6,556	168	168	168		945	40
41	WALLCOVERING, CARPETING, ARCHITECT WORK	1999	58,243	2,118	27.5	2,118		10,502	41
42	WALLCOVERING, ALARMS/ELECTRIC WORKS	1999	27,515	1,000	27.5	1,000		4,876	42
43	REMODEL KITCHEN/WALLCOVERINGS/DRY WALL	1999	11,104	404	27.5	404		1,936	43
44	DINING RMS/WASHROOM - REMODEL/NEW ROOF	1999	165,984	6,035	27.5	6,035		28,416	44
45	LANDSCAPING/SECURITY PROJECT	1999	38,968	1,417	27.5	1,417		6,554	45
46	CONCRETE PATIO/DRAINAGE/DUCTWORK	1999	26,186	952	27.5	952		4,324	46
47	FLOOR TILES/WALLCOVERING/WALL REPAIRS	1999	127,185	4,624	27.5	4,624		20,616	47
48	IRRIGATION SYSTEMS/BTY STATIONS	1999	26,058	947	27.5	947		4,143	48
49	NEW ADDITION/EXHAUST FANS/INTERIOR WORK	1999	843,269	30,661	27.5	30,661		129,036	49
50	REMODEL-OFFICES/BATHROOMS/DINING	2000	72,465	2,635	27.5	2,635		10,430	50
51	FIRE DAMPERS AND FLOOR GRILLES	2000	5,226	190	27.5	190		752	51
52	DOORS/LAUNDRY RM/CORRIDOR - REMODEL	2000	64,257	2,336	27.5	2,336		8,469	52
53	ELEVATOR OPERATION PANEL	2000	4,490	163	27.5	163		591	53
54	LINT COLLECTOR/REMODELING PLANS	2000	7,595	276	27.5	276		955	54
55	SPRINKLER SYSTEMS	2000	8,550	311	27.5	311		1,076	55
56	ELEVATOR WANDERGUARD SYSTEM	2000	5,282	192	27.5	192		648	56
57	KITCHEN REMODELING/CARPETING	2000	82,957	3,016	27.5	3,016		10,180	57
58	HOT WATER REC. - MIXING VALVE & CIRCUIT SETTERS	2000	8,604	313	27.5	313		1,030	58
59	FRESH AIR INTAKES/ROOF STANDS	2000	23,244	845	27.5	845		2,782	59
60	FIRE ALARM/DOORS	2000	6,184	225	27.5	225		741	60
61	PARKING LOT EXPANSION	2000	35,624	1,295	27.5	1,295		4,263	61
62	GENERATORS	2000	92,626	3,368	27.5	3,368		10,806	62
63	LANDSCAPING/SECURITY PROJECT	2000	12,625	842	15	842		2,946	63
64	RESIDENTROOM REMODELING & FURNISHING	2000	67,311	2,447	27.5	2,447		7,851	64
65	PATIENT WANDERING SYSTEM	2000	14,541	529	27.5	529		1,697	65
66	SIR FREE LINT FILTER	2000	1,399	51	27.5	51		164	66
67	NEW ROOF	2000	20,995	763	27.5	763		2,385	67
68	RESIDENT ROOM REMODELING & FURNISHING	2000	103,610	3,767	27.5	3,767		11,772	68
69	ROOF REPAIRS	2000	3,300	120	27.5	120		375	69
70	TOTAL (lines 4 thru 69)		$ 5,281,939	$ 105,798		$ 180,787	$ 74,989	$ 2,387,566	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,281,939	$ 105,798		$ 180,787	$ 74,989	$ 2,387,566	1
2									2
3	ROOF REPAIR & METACAULK FIRE STIP	2000	11,211	408	27.5	408		1,241	3
4	ROOF TOP HVAC UNIT	2000	7,350	267	27.5	267		812	4
5	ELECTRICAL WORK/RESIDENT RMS REMODEL	2000	109,053	3,965	27.5	3,965		12,061	5
6	REMOVE/INSTL FLOORING & DRYWALL-KITCHEN,LNDR	2001	16,675	606	27.5	606		1,743	6
7	METAL SUPPORTS ON AIR RETURNS TO ROOF	2001	3,300	120	27.5	120		345	7
8	INSTALL HYDRAULIC PUMPING UNIT-KITCHEN ELEVAT	2001	7,495	273	27.5	273		762	8
9	REPLACE WATER CLOSETS & FLUSH VALVES-KITCHEN	2001	7,737	281	27.5	281		738	9
10	NEW HALL DOOR LOCKING ASSEMBLIES-ALL FLOORS	2001	2,885	105	27.5	105		267	10
11	PUMP FOR IRRIGATION SYSTEM	2001	1,825	66	27.5	66		168	11
12	INSTALL 4" FLOOR CLEANOUT ON SANITARY WASTE LIN	2001	6,783	247	27.5	247		504	12
13	INSTALLED 4 ELECTRIC HEATERS - CUSTOM	2002	5,297	193	27.5	193		378	13
14	ELECTRICAL WIRING FOR DISHWASHER & BOOSTER HT	2002	14,988	545	27.5	545		1,067	14
15	SHWR RM REPAIRS, REMOVE OLD & FURNISH/INSL. NEW	2002	26,388	959	27.5	959		1,879	15
16	REPLACED GEARBOX ON INNER SLIDING ELEC. DOOR	2002	2,289	83	27.5	83		107	16
17	REMOVED & INSTALLED 2 HEAT EXCHANGERS	2002	2,040	74	27.5	74		89	17
18	REMOVE & INSTALL ROOFTOP HEAT EXCHANGER	2002	1,523	55	27.5	55		57	18
19	PARKING LOT - REMOVE AND REPLACE ASPHALT	2002	87,477	6,047	15	6,047		8,960	19
20	F&I ONE INFRA RED DOOR SCREEN ON SERV. ELEVATOR	2003	1,350	31	27.5	31		31	20
21	INSTALL 3/4" HP SUMP PUMP & 1-1/2 CK VALVE	2003	1,320	26	27.5	26		26	21
22	INSTALL WATER SOFTENER	2003	2,400	40	27.5	40		40	22
23	S-452E SINGLE SOFTENER; 450,000 GRAINS	2003	9,598	160	27.5	160		160	23
24	SUPLY & INSTALL WIRING FOR NEW 208-VOLT FREEZER	2003	1,651	18	27.5	18		18	24
25	REMOVE & INSTALL AZT FLOOR, RMS 602,611,614,905,702	2003	3,666	6	27.5	6		6	25
26									26
27			ADJ TO SL	74,989			(74,989)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,616,240	$ 195,362		$ 195,362	$	$ 2,419,025	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 776,722	$ 74,554	$	$ (74,554)	3-15 YRS	$ 249,574	71
72	Current Year Purchases	136,838	72,069		(72,069)	3-15 YRS		72
73	Fully Depreciated Assets	9,150					9,150	73
74	RELATED PARTY	67,480	8,682	8,682			64,323	74
75	TOTALS	$ 990,190	$ 155,305	$ 8,682	$ (146,623)		$ 323,047	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,720,775	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 350,667	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 204,044	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (146,623)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,742,072	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 17,812 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE RAM PR 2W	$ 295.13	$ 3,542	17
18					18
19					19
20					20
21	TOTAL		$ 295.13	$ 3,542	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER AIDE	104

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	X
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 2,092	$	$ 2,092
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 2,092	$	$ 2,092
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,092			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 125,328	$		$ 125,328	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			35,333			35,333	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			154,539			154,539	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				101,336		101,336	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, RENTALS, I.V. TPY & Other (specify): MEDICAL SUPPLIES	39-2					82,561		82,561	13
14	TOTAL			$		$ 315,200	$ 183,897		$ 499,097	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 293,597	$ 477,336	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 43,709)	1,441,680	1,441,680	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,327	152,024	6
7	Other Prepaid Expenses	16,094	16,474	7
8	Accounts Receivable (owners or related parties)	2,763	76,390	8
9	Other(specify): ESCROW DEPOSITS		675,621	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,812,461	$ 2,839,525	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		98,000	13
14	Buildings, at Historical Cost		2,111,156	14
15	Leasehold Improvements, at Historical Cost		3,101,539	15
16	Equipment, at Historical Cost	922,710	922,710	16
17	Accumulated Depreciation (book methods)	(699,874)	(3,250,888)	17
18	Deferred Charges	410	52,483	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 223,246	$ 3,035,000	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,035,707	$ 5,874,525	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 407,259	$ 414,829	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	95,571	95,571	28
29	Short-Term Notes Payable		223,927	29
30	Accrued Salaries Payable	118,052	118,052	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,173	16,173	31
32	Accrued Real Estate Taxes(Sch.IX-B)		106,812	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	823,795	823,795	36
37	DUE TO IDPA	87,671	87,671	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,548,521	$ 1,886,830	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,876,024	1,876,024	39
40	Mortgage Payable		4,826,200	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,876,024	$ 6,702,224	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,424,545	$ 8,589,054	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,388,838)	$ (2,714,529)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,035,707	$ 5,874,525	48

*(See instructions.)

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,309,300)	1
2	Restatements (describe):		2
3	ADJ. FOR DEPRECIATION	(8,339)	3
4	ROUNDING ADJ.	(3)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,317,642)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	118,804	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(190,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (71,196)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,388,838)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,005,046	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,005,046	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,580	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,580	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,475	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,475	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,022,101	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,309,594	31
32	Health Care	3,830,277	32
33	General Administration	2,953,498	33
	B. Capital Expense		
34	Ownership	1,197,498	34
	C. Ancillary Expense		
35	Special Cost Centers	499,097	35
36	Provider Participation Fee	113,333	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,903,297	40
41	**Income before Income Taxes (line 30 minus line 40)****	118,804	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 118,804	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,911	2,086	$ 76,374	$ 36.61	1
2	Assistant Director of Nursing	1,956	2,099	63,436	30.22	2
3	Registered Nurses	25,229	26,790	758,403	28.31	3
4	Licensed Practical Nurses	23,830	25,608	633,013	24.72	4
5	Nurse Aides & Orderlies	118,953	123,469	1,717,551	13.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,554	4,999	74,444	14.89	8
9	Activity Director	2,689	2,911	37,329	12.82	9
10	Activity Assistants	7,570	8,015	70,891	8.84	10
11	Social Service Workers	3,041	3,524	50,560	14.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	11,746	12,501	160,165	12.81	14
15	Cook Helpers/Assistants	17,044	17,370	136,158	7.84	15
16	Dishwashers					16
17	Maintenance Workers	2,029	2,086	38,906	18.65	17
18	Housekeepers	26,078	27,138	236,038	8.70	18
19	Laundry	5,653	5,996	54,237	9.05	19
20	Administrator	1,981	2,086	118,369	56.74	20
21	Assistant Administrator	2,509	2,946	69,531	23.60	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,439	10,160	159,357	15.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,071	7,346	152,190	20.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	273,283	287,130	$ 4,606,952 *	$ 16.04	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	243	$ 11,200	1-3	35
36	Medical Director	36	6,000	9-3	36
37	Medical Records Consultant	48	2,112	10-3	37
38	Nurse Consultant	644	27,509	10-3	38
39	Pharmacist Consultant	96	2,400	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	43	2,394	11-3	44
45	Social Service Consultant	24	1,646	12-3	45
46	Other(specify)	36			46
47	UTILIZATION REVIEW		6,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,170	$ 59,261		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	101	$ 4,991	10-3	50
51	Licensed Practical Nurses	8	281	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	109	$ 5,272		53

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KIM KOHLS	ADMIN		$ 118,369
VIVIAN MC CAIN	ASST ADMIN		69,531
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 187,900

B. Administrative - Other

Description	Amount
FIRST HEALTHCARE - MANAGEMENT FEES	$ 800,192
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 800,192

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		242,685
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 242,685

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 127,212
Unemployment Compensation Insurance	42,297
FICA Taxes	347,615
Employee Health Insurance	265,971
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	11,725
EMPLOYEE PHYSICAL EXAMS	314
PENSION/PROFIT SHARING PLANS	7,866
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 803,000

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,430
Health Care Worker Background Check	1,238
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	53,439
TRUST/FRANCHISE/CONTRIB/ETC	3,349
LICENSES & PERMITS	7,103
DUES & SUBSCRIPTIONS	10,596
MGMT CO ALLOCATION	1,809
TRUST/FRANCHISE/CONTRIB/ETC	(3,349)
Less: Public Relations Expense	(31,133)
Non-allowable advertising	(8,859)
Yellow page advertising	(13,447)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,176

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	14,394
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,394

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINT/DECORATING	2001	$ 2,369	3	$	$ 395	$ 790	$ 790	$ 394	$	$	$	$
2	PAINT/DECORATING	2002	2,374	3			396	791	791	396			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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18													
19													
20	TOTALS		$ 4,743		$	$ 395	$ 1,186	$ 1,581	$ 1,185	$ 396	$	$	$

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL. COUNCIL ON LTC - $11537**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,055** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **113,333**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees